CMHSP AND SUBSTANCE ABUSE INTEGRATION STATUS REPORT

(FY2007 Appropriation Bill - Public Act 330 of 2006)

May 1, 2007

Section 470: (1) For those substance abuse coordinating agencies that have voluntarily incorporated into community mental health authorities and accepted funding from the department for administrative costs incurred pursuant to section 468 of this act, the department shall establish written expectations for those community mental health services programs, prepaid inpatient health plans, and substance abuse coordinating agencies and counties with respect to the integration of mental health and substance abuse services. At a minimum, the written expectations shall provide for the integration of those services as follows: (a) Coordination and consolidation of administrative functions and redirection of efficiencies into service enhancements. (b) Consolidation of points of 24-hour access for mental health and substance abuse services in every community. (c) Alignment of coordinating agencies and prepaid inpatient health plans boundaries to maximize opportunities for collaboration and integration of administrative functions and clinical activities. (2) By May 1, 2007, the department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office on the impact and effectiveness of this section and the status of the integration of mental health and substance abuse services.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
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STATE OF MICHIGAN

JENNIFER GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

JANET OLSZEWSKI
DIRECTOR

May 1, 2007

A REPORT TO COMPLY WITH THE REQUIREMENTS IN SECTION 470(2) OF PUBLIC ACT 330

BACKGROUND

Section 468 of Act 330 of the Public Acts of 2006 (the Department's Appropriation Act) directs the department[1] to promote the integration and redesignation of substance abuse coordinating agencies (CAs) into community mental health services programs (CMHSPs). This same section indicates that the department can make certain financial "accommodations or adjustments" as incentives for such integration and redesignation.

The designation process, functions, eligible entities, and duties for a city, county or regional substance abuse coordinating agency are specified in Sections 333.6226 and 333.6228 of the Michigan Compiled Laws. The statute indicates that the "…administrator[2] shall designate, and may change the designation of, city, county or regional coordinating agencies." When the administrator makes a designation of a city, county or regional coordinating agency, the decision is subject to the approval of certain elected officials, councils, or commissions (i.e., for a city CA designation, the mayor and the city council; for a county or regional CA designation, the affected board or boards of commissioners).

While a coordinating agency *may* be a CMHSP, a CA *may also be* a local public health agency or a public or private nonprofit agency that is licensed or organized to provide human services. In short, there is nothing in the Public Health Code (Act 368 of 1978, Part 62, Substance Abuse Services) that establishes a statutory preference for CAs to be CMHSPs.

[1] This stipulation in Section 468 reads as follows: "To foster a more efficient administration of and to integrate care in publicly funded mental health and substance abuse services, the department shall recommend changes in its criteria for the incorporation of a city, county, or regional substance abuse coordinating agency into a local community mental health authority that will encourage those city, county, or regional coordinating agencies to incorporate as local community mental health authorities."

[2] The "administrator" is defined in MCL 333.6102 (1), as the administrator of the office of substance abuse services. Subsequent Executive Orders have changed the status and name of the former "office of substance abuse services." The current "administrator" is the Director of the Office of Drug Control Policy and Substance Abuse Services, within the Michigan Department of Community Health.

Currently, there are 16 designated coordinating agencies statewide. They can be classified according to *level* (city, county, regional) and/or by *type* of CA entity (CMHSP, public or private nonprofit agency, public health department, etc.).

TABLE A
CA BY LEVEL

City	1
County	5
Regional	10

TABLE B
CA BY TYPE OF ENTITY

Health Department – City CA	1
Health Department – Single County CA	2
Health Department – Regional CA	1
CMHSP – Single County CA	3
CMHSP – Regional CA	4
Public/Private Agency Regional CA	5

As shown in Table B, nearly half (7) of the 16 CAs are already situated within a CMHSP. Three (3) of the 7 CAs that are housed within a CMHSP are the "single county" CA-CMHSP type; these are primarily larger, more populous counties. The 4 other CMHSPs that are also the CA are "regional" coordinating agencies; a particular CMHSP serves as the CA for multiple counties.

CA DESIGNATION CRITERIA, CONSOLIDATION, AND INTEGRATION

There are no formally established or officially promulgated criteria for CA designation. When the current statute relating to substance abuse services was enacted (PA 368 of 1978), coordinating agencies formed under previous legislation were initially maintained as CAs. Over time, the "Office of Substance Abuse Services" (originally a Type 1 Agency, later changed through Executive Order) worked with cities and counties to establish CA boundaries and to designate CA organizations that were acceptable to the parties and capable of performing the functions and duties of a CA as outlined in MCL 333.6228.

In the 1990s, Legislative interest shifted to **consolidation** of CAs and to achieving administrative efficiencies. The 1996 appropriation act for the Department of Public Health (DPH) that housed the Center for Substance Abuse Services contained a boilerplate provision that directed DPH to establish a taskforce to make recommendations regarding consolidation, regionalization and reduction of administrative costs. The findings and recommendations of this taskforce resulted in the merger of several CAs and reduced the number of CAs from 18 to 15. One additional regional CA was later established in 2001 (Bay-Arenac CMHS), bringing the total number of CAs to the current count of 16.

In May 2001, in response to requests from several counties to withdraw from existing regional coordinating agencies (combined with proposals for the creation of new CAs situated within the county-sponsored CMHSP), the Department of Community Health (DCH) published draft criteria for CA designation. The criteria identified the statutory duties and functions of a CA, and listed the capabilities, competencies, processes and infrastructure necessary to fulfill the functions and duties of a coordinating agency. While the draft criteria outlined requisite technical and operational qualifications for CA designation, an additional department consideration in assessing requests for CA designation or redesignation, was whether the proposed change would undo or undermine earlier **consolidation** achievements. That is, while **integration** of CAs within CMHSPs was an important policy objective, DCH believed that such changes should not come at the price of reversing past CA consolidations; i.e., integration should not increase the total number of CAs.

STATUS OF INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The department's 2001 draft criteria for counties and CMHSPs requesting CA designation, though unofficial, still provide an adequate outline of expectations, core competencies, and infrastructure capabilities that must be demonstrated or assured before the "administrator" will consider redesignation requests. However, while some counties and their respective CMHSPs have officially pursued redesignation from the administrator by requesting to become the CA for their area, most requests submitted to date have displayed a conspicuous weakness: while fostering mental health-substance abuse integration, the redesignation requests contravene the "consolidation principle" since they propose or imply the creation of new, single county, CA-CMHSPs, hence increasing the total number of CAs.

The informal 2001 criteria developed by the department for CA designation were and are not inimical to mental health and substance abuse integration. The real challenge has been and remains to realize integration *without* eviscerating the CA consolidations and administrative efficiencies achieved in the 1990s. This requires persuading multiple counties, involved in different CA regions, to collectively agree to redraw CA boundaries and to acquiesce in proposed changes that designate a particular CMHSP as the CA for redrawn regions, all without further increasing the total number of CAs. The modest financial "adjustments and accommodations" authorized in Section 468 to promote integration have provided insufficient inducement for CMHSPs, CAs and the affected counties to reach consensus on redesignation. The department continues to work with the interested and affected parties (counties, CAs, PIHPs/CMHSPs) to devise consensus proposals that achieve regional mental health-substance abuse integration and alignment of PIHP/CMHSP and CA boundaries, without increasing the number of CAs beyond the present number of such entities.